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Nurse Rounding: A Plan To Decrease Patient Falls During a Pandemic

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Conflict of Interest Statement

The author declares that there is no conflict of interest.

Funding

This project received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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Abstract

Aims: This paper describes the design of a purposeful nurse hourly rounding pilot to decrease the incidence of patient falls on a COVID-19 designated unit in an acute hospital setting.

Background: Falls in acute care hospitals are a persistent patient safety problem. The COVID-19 pandemic has added to concerns to safely care for high-risk COVID patients while mitigating the risk of infection for frontline staff.

Methods: A PNHR pilot project was designed for implementation in a 28-bed COVID-19 designated unit in a not-for-profit acute hospital in California. A modified PNHR rounding tool guides focus points for every nurse/patient interaction. Pre- and post-implementation surveys are used to obtain feedback from the frontline staff.

Results: The pilot is in an early stage of implementation with data not yet available. Pre-implementation survey data indicate increased stress and anxiety from frontline staff.

Conclusion: It is anticipated that an active focus on patient safety and a united approach by the entire care team will decrease the incidence of patient falls on a COVID-19 acute nursing unit.

Implications for Nursing Management: This paper describes how the psychological and safety needs of the frontline staff are addressed in the design of a protocol to reduce patient falls.

Key Words: Nurse, hourly rounding, fall prevention, patient safety, COVID-19

The global pandemic brought about by the coronavirus disease (COVID-19) exacerbates an existing problem with patient falls in the acute hospital setting. Patients infected by COVID-19, especially older adults, present with higher acuity health conditions accompanied by more complications, and require heightened attention from the entire care team. SARS-CoV-2, the virus causing the disease, does not discriminate and can potentially infect anyone with sufficient exposure to it. The lethality of the virus in combination with the many unknowns about how the disease manifests and can be treated, has made COVID-19 central to decisions about quality of care and patient safety. This paper describes an approach to purposeful nurse hourly rounding adopted by a COVID-19-designated acute care unit of an urban hospital to ensure staff and patient safety during the pandemic. The pilot program has the specific aims of reducing patient falls on the unit and mitigating staff and patient anxiety over safe care.

Background

Health systems were caught off-guard in early 2020 by the surge of COVID-19 patients and the complexity of treating patients ill from such a highly infectious and poorly understood disease agent. In a COVID-19 designated unit of an acute care hospital in northern California, infection control protocols were quickly put in place—and put to the test. Frontline staff were immediately confronted with uncertainty surrounding safely caring for patients and protecting themselves from exposure to the virus. The nursing staff lacked confidence about the hospital's ability to deal with the virus, the availability of personal protective equipment (PPE), and the adequacy of procedures in place to keep them safe. Hospital leadership was challenged to quickly put in place measures to ensure that staff, patients, and families felt safe in the short term while existing hospital safety and infection control protocols were adapted to the pandemic and put in place for the duration.

The heightened stress and increased workload imposed on the staff by the pandemic made the task of communicating new protocols for fall prevention more difficult. In the COVID-19 nursing unit, the leadership team had to address the fears and anxieties of the frontline staff first. This was accomplished by the unit leadership team conducting huddles with the frontline staff every shift to facilitate transparency and timeliness of communication and address all questions/ concerns. With the staff reassured about their own safety, an adaptation of purposeful nurse rounding that incorporates fall prevention could be introduced and a pilot implemented.

Setting

The setting for the purposeful hourly nurse rounding pilot project is a 28-bed COVID-19 designated acute care nursing unit in a northern California urban hospital. The unit has approximately 70 registered nurses (RNs) and 30 certified nursing assistants (CNAs). The RNs and CNAs are critical to ensuring that rounding is done hourly from 7 am to 10 pm, and every two hours from 10 pm to 6 am. Decreasing the frequency of rounding during nighttime hours is intended to minimize interruptions to sleep for patients. The pilot was initiated in October 2020 and will run until June 2021.

Nurse Rounding and Fall Prevention

Nurse hourly rounding is an evidence-based, practical intervention in the acute care hospital setting to reduce the incidence of patient falls. Hicks (2015) conducted a meta-analysis of 14 independent studies to determine nursing best practice guidelines for fall prevention in hospital acute care settings. Twelve out of the 14 studies demonstrated a positive association between nurse hourly rounding and a reduction in patients falls. The two studies with the most impactful results reported 54.7% and 39% decreases in falls per 1,000 patient days. Brosey and March (2015) conducted a study to gauge the effect of nurse hourly rounding on the incidence of

falls and hospital-acquired pressure injuries in a 24-bed medical surgical hospital acute care unit. Twelve months from implementation, fall incidence had decreased by 31 percent, from 3.18 to 2.19 per 1,000 patient days. Spano-Szekely et al. (2019) found implementation of an evidence-based hospital fall protocol that included nurse hourly rounding to reduce patient falls by 54% from 2.51 to 1.15 falls per 1,000 patient days.

Methodology

Design of the Intervention

Change Theory Framework

The theoretical framework for the pilot is Lewin's theory of change (Wojciechowski et al., 2016). The three phases of Lewin's theory, unfreezing, changing, and refreezing, guide the project's design and implementation. The unfreezing phase is the time when the status quo of prevalence of patient falls was deemed as unacceptable, a decision was made to make changes, and the concepts of purposeful nurse hourly rounding and the theory of human caring were introduced to staff. The changing phase is the implementation phase of the PNHR project.

The refreezing phase is the integration of PNHR into patient care protocol, as determined by the outcomes of the PNHR pilot. In refreezing the PNHR protocol, ongoing continuous improvement processes such as audits and timely communication to staff, will be critical to ensure long-term sustainability as standard work of the frontline staff.

Nursing Theory Framework

The nursing theory guiding the PNHR initiative is Jean Watson's theory of human caring (Watson, 2020). Watson's theory incorporates the principles of caring, compassion, and the treatment of the whole person as an entire being in relation with the caring-healing environment. Watson's theory guided design of the pilot in acknowledging that nurses are first and foremost

unitary human beings that must be cared for, attended to, and appreciated. Ensuring the safety, security, and welfare of the frontline staff is a necessity for the team cultivate the fortitude needed survive and thrive in very challenging circumstances.

Rounding Protocol

Established concepts of nurse hourly rounding are focused on 3 Ps: pain, potty, position or 4 Ps: pain, potty, position, and personal belongings (Mitchell, 2017). The Purposeful Nurse Hourly Rounding (PNHR) intervention for the pilot has five essential elements, the “5 Ps,” which are assessed at every patient/nurse interaction.

- Pain: Assess for pain or discomfort and intervene as necessary.
- Potty: Assess for toileting needs and help the patient as needed.
- Position: Assess for comfort or the need to reposition in bed.
- Protect: Ensure fall precautions are in place and the environment is free of hazards.
- Provide: Make sure all necessary items are within the patient's reach (e.g., call light, eyeglass, hearing aids, dentures, food).

Communication Protocol

The evidence-based AIDET communication structure of the Studer Group (2020) is the guiding protocol for communication in the pilot. AIDET is the acronym for acknowledge, introduce, duration, explanation, and thank. Each nurse is to use a standard greeting, introducing themselves by name and role and informing the patient of hourly rounding during the day and every two hours at night. The nurse is to ask the "Is there anything else I can do for you before I leave?" to ensure that the patient is safe, comfortable, and all needs have been addressed.

Survey

Pre- and post-implementation surveys will be offered on a voluntary basis to all frontline staff in

the nursing unit. All survey responses will be anonymized to ensure confidentiality. The purpose of the survey is to assess for baseline knowledge, gather staff feedback/suggestions, and ascertain the impact of the pilot on patient safety outcomes. The pre-implementation survey consists of 13 items: Yes/No questions on job role and baseline knowledge of the nurse hourly rounding concept; a question with a Likert scale response on support for the PNHR pilot; and open-ended questions to elicit narrative responses. The pre-implementation survey offered the frontline staff an opportunity to comment on anticipated barriers, offer suggestions on how to improve communication with the patient and with each other, and share insights on ways to implement the project successfully. The responses to the pre-implementation survey were essential in helping the unit leaders anticipate challenges and address them proactively with the frontline staff while incorporating suggestions for improvement as part of the project planning process.

The post-implementation survey consists of seven items: Yes/No questions to evaluate the overall impression of the PNHR pilot in terms of education, training, and leadership support; open-ended-questions on what did and did not go well; and a request for improvement. As de novo surveys created for the pilot, the surveys have not been validated. Responses to the post-implementation survey will be analyzed by the unit leadership team. Additional feedback from staff solicited during staff meetings and group discussions over the course of the pilot will be incorporated into post-implementation decisions for the sustainability of PNHR in the unit

Fall Prevention

Patient falls are commonly used as a metric for patient safety in acute care (Agency for Healthcare Research and Quality, 2018) and are the quantitative indicator for this pilot. The primary outcome measure for the pilot is the number of falls per 1,000 patient days, expressed

as a percentage reduction in falls over the course of the pilot. The source of the data is the hospital's MIDAS Safety Alert System administered by the Quality and Risk Management team. Internally, the Quality and Risk Management team collects, analyzes, and reports data to nurse leaders as close to real-time as possible. For the purposes of this change in practice quality improvement initiative, the project lead analyzed and reported fall data anonymously, on a weekly basis, and shared with project key stakeholders for continuous quality improvement.

Data Analysis

Baseline data will be cross-checked with post-implementation statistics to evaluate the efficacy of the intervention. Descriptive statistics will be used to evaluate changes in patient fall incidence. The P-value will be obtained to determine if changes are due to the intervention or a random occurrence. The specific aim is a ten percent decrease from baseline in patient falls at nine months from initiation of the PNHR intervention.

Limitations

Validity and reliability of results obtained in this study may be affected by the staff's increased workload and strain resulting from the COVID-19 pandemic. Additional safety measures put in place for the pandemic (e.g., PPE, distancing) may affect the perception of PNHR by both patients and staff. As the pilot is being conducted in a designated COVID-19 unit that is treating elderly, high-acuity patients with comorbidities, the severity of their conditions requires more intense medical and nursing management, potentially skewing outcomes and limiting generalizability of the results. The pre- and post-implementation surveys were designed for this pilot and have not been validated or tested for reliability.

Conclusion

Evidence in the literature suggests that a proactive, structured, and purposeful nurse hourly rounding process decreases the incidence of patient falls and falls with injuries in the acute care hospital setting. If successful, the pilot can contribute to developing an infrastructure and standardized processes to prevent avoidable patient falls and create a standard work protocol for purposeful nurse hourly rounding.

Implications for Nursing Management

The COVID-19 pandemic has increased the strain on frontline nursing staff and made the provision of safe patient care more difficult. The evolving healthcare crisis remains very physically and emotionally taxing for healthcare workers. During this difficult time, the Watson's human caring principles provide a moral-ethical foundation for compassionate and conscientious professional nursing practice. Frontline staff deserve compassion, empathy, and support from hospital leaders. Addressing staff stress and anxiety about their own safety and well-being concerns is necessary before education and training for process changes in patient care can take place.

Conflict of Interest Statement

The author declares that there is no conflict of interest.

Funding

This project received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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